

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
03532					CERTIFICATE OF DEATH					05078									
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 40 minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital Inc.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsburg d. STREET ADDRESS 09-1					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Charles Middle MacAuthor Last Aldridge					4. DATE OF DEATH Month March Day 14 Year 19 67														
5. SEX male		6. COLOR OR RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/14/67		9. AGE (in years last birthday) yrs. 09-1 Months 09-1 Days 09-1 Hours 09-1 Min. 09-1		10. IF UNDER 1 YEAR Months 09-1 Days 09-1 Hours 09-1 Min. 09-1		11. IF UNDER 24 HRS. Hours 09-1 Min. 09-1							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -					10b. KIND OF BUSINESS OR INDUSTRY -					11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles MacAuthor Aldridge					14. MOTHER'S MAIDEN NAME Diane Sheffield														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. No					17. INFORMANT mother					Address Williamsburg, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 7-25 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Prematurity DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH									
21. I certify that (I) (this hospital) attended the deceased from 3/14 , 1967, to 3/14 , 1967, that (I) (we) last saw the deceased alive on 3/14 , 1967, and that death occurred at 1:10 PM , from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
22a. SIGNATURE [Signature]					22b. DATE SIGNED 3-14-67														
22c. PHYSICIAN'S NAME (Type) Dr. J. Edwin Fassett					22d. ADDRESS 623 High Street, Cambridge, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 3/18/67					23c. NAME OF CEMETERY OR CREMATORY Bethel					23d. LOCATION (City, town or county) (State) Cambridge, Md.				
24. FUNERAL DIRECTOR St Clair-521 High St. Cambridge, Md.					25a. REC'D BY REGISTRAR APR 27 1967					25b. REGISTRAR'S SIGNATURE [Signature]									

1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03533 CERTIFICATE OF DEATH 03528

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN b 40 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 1405 Race Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTIE MAY BOOZE First Middle Last		4. DATE OF DEATH March 27 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1900
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Hudson, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jehn R. Hubbard		14. MOTHER'S MAIDEN NAME Daisy May Marshall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Mr. Milton L. Booze, Cambridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DISEASE WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Pancreatitis 584X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Common Duct Stone DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 4 days unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-23, 1967 to 3-27, 1967 , that (I) (we) last saw the deceased alive on 3-27 1967 , and that death occurred at 4:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE W. Baumann		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wilbur N. Baumann, M.D.		22d. ADDRESS 10 Aurora St., Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 29 1967	
23c. NAME OF CEMETERY OR CREMATORY Spedden-Seward Cemetery		23d. LOCATION (City, town or county) (State) James, Dor. Co., Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR MAR 31 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE [Signature]	

03828

03828

1. The first part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1890, 1891, and 1892.

2. The second part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1890, 1891, and 1892.

3. The third part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1890, 1891, and 1892.

4. The fourth part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1890, 1891, and 1892.

5. The fifth part of the document is a list of names and dates. The names are: John, Mary, and James. The dates are: 1890, 1891, and 1892.

The following is a list of names and dates. The names are: John, Mary, and James. The dates are: 1890, 1891, and 1892.

3-22 of 3-22 03

3-22 03

W. J. ...

The following is a list of names and dates. The names are: John, Mary, and James. The dates are: 1890, 1891, and 1892.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03534					03529									
PLACE OF DEATH a. CDUNITY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE									
Dorchester					Maryland									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)									
Cambridge					Cambridge									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS									
313 Talbot Ave.,					313 Talbot Ave.,									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last Ida Ann Bradley					Month Day Year March 6, 1967 19									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Female		White		WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec. 2, 1880		86 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
Homemaker						Cambridge, Md., R.D.		U.S.						
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
William Shannahan					Margaret Phillips									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
No										313 Talbot Ave., Mrs. Wm. F. Brohawn, Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Massive Cerebral Hemorrhage (b) Cerebral arterio-sclerosis (c) DUE TO Arterio sclerosis generalized										INTERVAL BETWEEN ONSET AND DEATH 5 - 10 Min. 1 - 2 yrs. 5 - 10 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage with left Hemiplegia 2-6-67												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (the hospital) attended the deceased from 2-6-1967, to 3-6-67, 1967, that (I) (we) last saw the deceased alive on 3-4-1967, and that death occurred at 4:15 PM from the causes and on the date stated above.														
22a. SIGNATURE Eldridge H. Wolff						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-6-67						
22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M. D.						22d. ADDRESS 6 Aurora Street, Cambridge, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)						
Burial			March 8, 1967		Green Lawn Cemetery			Cambridge, Md.						
24. FUNERAL DIRECTOR Kenneth P. Thomas						ADDRESS Cambridge, Md.		25a. RECEIVED BY REGISTRAR MAR 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				

100

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
03535		Item #16 Film #4301 3/23/67 pc		03530							
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 4 months		a. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Finksburg					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 407 Oakley St.						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruby Pratt Brubaker			First Middle Last			4. DATE OF DEATH March 9 1967			Month Day Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 April 1881		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Breckenridge Missouri				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Charles Pratt						14. MOTHER'S MAIDEN NAME Harriett Morse					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-52-5899		17. INFORMANT Address Cambridge Md. Mrs. Alton Sellers 407 Oakley St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary occlusion											
DUE TO											
Conditions, if any, which gave rise to immediate cause (b)											
DUE TO											
(a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Mace Jr.</i>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 3/10/67		
EXAMINER'S NAME (Type) John Mace Jr. M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) Cambridge, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 13 Mar 1967		22c. NAME OF CEMETERY OR CREMATORY All Saints Episcopal				22d. LOCATION (City, town, or county) (State) Reistertown Md.	
23. FUNERAL DIRECTOR <i>Henry H. Hov...</i>						ADDRESS Cambridge Md. 21613			24a. REC'D BY REGISTRAR MAR 14 1967		
						24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATION

2000-2001

FOR STATE HEALTH DEPT

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03536		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				03531			
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b 40 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 900 Race Street					d. STREET ADDRESS 900 Race Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle KINCAID Last BUSICK					4. DATE OF DEATH Month March Day 15 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1881		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Cuyahoga Falls, Ohio			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unk					14. MOTHER'S MAIDEN NAME Unk				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-20-8495A		17. INFORMANT Mr. James G. Busick, Cambridge, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr. M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/18/67 Address (Street, city, town, or county) Cambridge, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Old Trinity Cemetery		23d. LOCATION (City or Town) (County) (State) Church Creek, Maryland			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland					25a. REC'D BY REGISTRAR MAR 21 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

1882

1882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 5 63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03537 05085											
1. PLACE OF DEATH a. COUNTY DORCHESTER b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CAMBRIDGE c. LENGTH OF STAY IN TB LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MD. b. COUNTY DORCHESTER c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CAMBRIDGE, MD d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Hattie Christian						4. DATE OF DEATH Month 3 Day 22 Year 1967					
5. SEX Female						6. COLOR OR RACE Negro					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 7/12/1900					
9. AGE (In years last birthday) 67						10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) DORCHESTER						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME Ida Mason					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO. INFORMANT Robert Christian Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) (e), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 2-1-1957 to 3-22-1967 , that (I) (we) last saw the deceased alive on 3-22-1967 , and that death occurred at PM , from the causes and on the date stated above.											
22a. SIGNATURE J. Edwin Fassett M.D.											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett											
22d. ADDRESS 623 High St Cambridge, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY Bethel											
23d. LOCATION (City, town or county) (State) Cambridge											
24. FUNERAL DIRECTOR'S SIGNATURE West Penn Home, Cambridge, Md. ADDRESS											
25a. REC'D BY REGISTRAR MAY 3 1967 DATE											
25b. REGISTRAR'S SIGNATURE Charles Judge											

MEDICAL CERTIFICATION



03538

CERTIFICATE OF DEATH

03532

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston - RURAL</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs.</u>				d. STREET ADDRESS <u>Eastern Shore State Hosp.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>D.</u> Last <u>Cox</u>				4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-14-86</u>	
9. AGE (In years or birthdate) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>27</u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		11. BIRTHPLACE (County & State or foreign country) <u>Maryland-TALCO</u>	
12. CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Daniel Cox</u>				14. MOTHER'S MARDEN NAME <u>Sarah Biery</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-32-7279</u>		17. INFORMANT <u>Records - Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 471X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>3:13 A</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>W. W. Rieckert</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>W. W. Rieckert</u>				22d. ADDRESS <u>E-New Market Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3-15-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		23d. LOCATION (City or Town) (County) (State) <u>Frederick, Md.</u>	
24. FUNERAL DIRECTOR <u>W. W. Rieckert</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03540

03534

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>		d. STREET ADDRESS <u>RFD #3 - Box 169</u>	
3. NAME OF DECEASED (Type or print) <u>Percy Lee Demby</u>		4. DATE OF DEATH <u>March 24 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-04</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Demby</u>		14. MOTHER'S MAIDEN NAME <u>Rester Tilghman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>22-16-1802</u>	
17. INFORMANT <u>Records - Hospital</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute</u> 4201 DUE TO (b) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from <u>3/22, 1967</u> , to <u>3/24, 1967</u> that the (we) last saw the deceased alive on <u>3/24, 1967</u> , and that death occurred at <u>4:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Donald R. Hylleberg</u>		22b. DATE SIGNED <u>3/24/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW CHAPEL</u>	23d. LOCATION (City or Town) (County) (State) <u>CHAPEL Talbot MD</u>
24. FUNERAL DIRECTOR <u>Washell Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03541

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY in 1b Vienna - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS R.F.D. #1, Box 219	
3. NAME OF DECEASED (Type or print) First ELWOOD Middle LUTHER Last DENNIS		4. DATE OF DEATH Month March Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1918
9. AGE (in years last birthday) yrs 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Edward Dennis		14. MOTHER'S MAIDEN NAME Martha Collins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 219-07-3838	
17. INFORMANT Sarah E. Dennis, Vienna, Md., RFD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage, stab wound of heart. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Was stabbed by wife.	
20c. TIME OF INJURY Month Day, Year 6 PM 3/24/67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Reid's Grove, Dor., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr. M.D.		22. DATE SIGNED 3/29/67 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 29, 1967	
23c. NAME OF CEMETERY OR CREMATORY Reid's Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Near Rhoadesdale, Md.	
24. FUNERAL DIRECTOR <i>John Frampton Jr.</i> J. J. Frampton and Son, Federalburg, Maryland		25a. APR 6 1967 BY REGISTRAR 25b. APR 6 1967 BY REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

03542

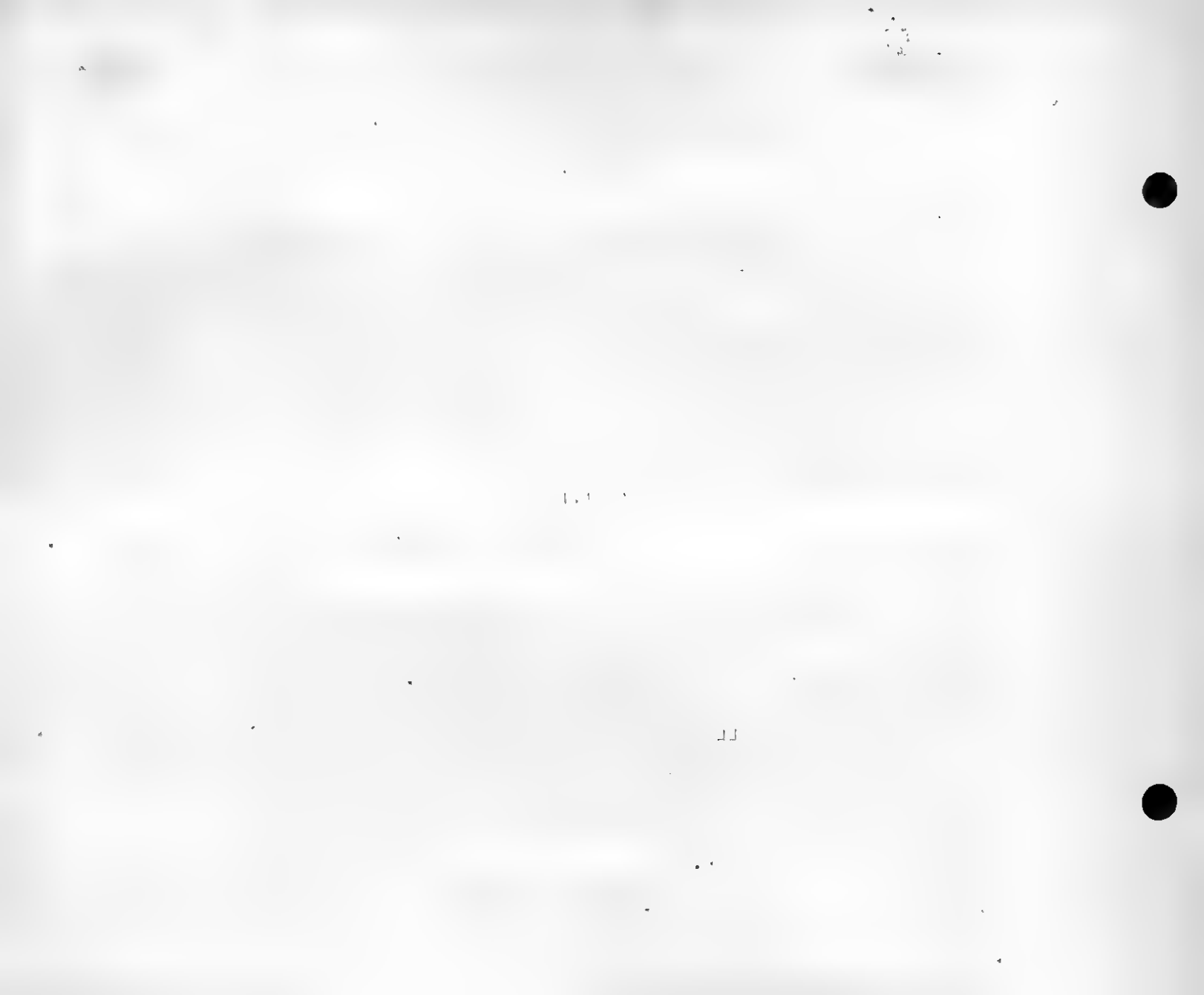
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03535

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MD. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. LENGTH OF STAY IN 1b 6 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN 14-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JA ES Middle GODFREY Last DILLON				4. DATE OF DEATH Month MARCH Day 13 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/05		9. AGE (In years lost birthday) yrs 61	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HEATING ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES RICARDS DILLON				14. MOTHER'S MAIDEN NAME MARY MCINTYRE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 282-03-7278		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 963X IMMEDIATE CAUSE (a) DUE TO MENINGITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO OLD GUN SHOT WOUND BRAIN ? (c)						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 6 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUT. <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) SHOT SELF WITH 22 GUN.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. SPRING 19 67 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) CHESTERTOWN KENT MD.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr. M.D. EXAMINER'S NAME (Type) JOHN MACE JR.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 3/13/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3-14-67		23c. NAME OF CEMETERY OR CREMATORY SILVERBROOK CREMATORY		23d. LOCATION (City or Town) (County) (State) WILMINGTON, NEWCASTLE, DEL.	
24. FUNERAL DIRECTOR Victor N. Kennedy, STILLBOND, M.D.				25a. REC'D BY REGISTRAR DATE MAR 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03543

CERTIFICATE OF DEATH

03536

1 PLACE OF DEATH a. COUNTY <u>ORCHESTER</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.</u> b. COUNTY <u>110R.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>13 YRS.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL, RT. #2</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY FRANCES DRYDEN</u>		4. DATE OF DEATH Month Day Year <u>MARCH 21 19 67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/26/79</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DID BURKE</u>		14. MOTHER'S MAIDEN NAME <u>MARY HADDOCK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>DIABETES</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> , 19 <u>53</u> , to <u>3/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> 19 <u>67</u> , and that death occurred at <u>11:25M</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Referrin C. Hernandez, M.D.</u>		22b. DATE SIGNED <u>3/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Referrin C. Hernandez, M.D.</u>		22d. ADDRESS <u>E.S.C. HOSPITAL, CAMBRIDGE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>March 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oliver Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Snow Hill Maryland</u>
24. FUNERAL DIRECTOR <u>Thomas F. Williams, Snow H. Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

03544

CERTIFICATE OF DEATH

03537

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY	
c. LENGTH OF STAY IN TB 15 DAYS		d. STREET ADDRESS 683 FITZWATER STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Brewster DUFFY		4. DATE OF DEATH MARCH 22 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1987 24-15-85
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR: Months 22 Days 22 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN SAUNDERS DUFFY		14. MOTHER'S MAIDEN NAME UNKNOWN ANNIE WILLIAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 213-12-5219	
17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO (b) Arteriosclerosis DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/7 , 1967, to 3/22 , 1967, that (I) (we) last saw the deceased alive on 3/22 , 1967, and that death occurred at 7:30 PM , from causes and on the date stated above.			
22a. SIGNATURE E. F. FERNANDEZ		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ERRAIN C. FERNANDEZ		22d. ADDRESS E.S.S.S. Cambridge, Dorchester, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-28-67	23c. NAME OF CEMETERY OR CREMATORY Friendship	23d. LOCATION (City or Town) (County) (State) Whiton - Worcester, Maryland
24. FUNERAL DIRECTOR Loretta L. Jolley - Jerry Rd. Salisbury Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03545

CERTIFICATE OF DEATH

03538

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 2, Easton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital			d. STREET ADDRESS Rt. 2, Easton		
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Ervin Glasco			4. DATE OF DEATH Month Day Year March 14 1967		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH II-II-1896	9. AGE (In years lost birthday) yrs. 70	10. IF UNDER 1 YEAR Months Days Hours Min. 4 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY sawmill		11. BIRTHPLACE (County & State, or foreign country) Federalsburg, Va.	
13. FATHER'S NAME John Glasco			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 220-32-8887		17. INFORMANT Franklin Lee Tilghman Address Rt. 2, box 110 Easton, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia; Cardiac Decompensation 442X DUE TO (b) Arteriosclerotic Cardiovascular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)					
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from December 1, 1966 to March 14, 1967 , that (I) (we) last saw the deceased alive on March 11, 1967 , and that death occurred at 3 M, from causes and on the date stated above.					
22a. SIGNATURE <i>J. Edwin Fassett</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 3-14-67	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 623 High St., Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Richard's Mem. Park	23d. LOCATION (City or Town) (County) (State) Easton Talbot Md.		
24. FUNERAL DIRECTOR G.H. Dashiell		ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR DATE MAR 21 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03546

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03539

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>	
c. LENGTH OF STAY IN 1b <u>Years</u>		d. STREET ADDRESS <u>Middle St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Linnie Rebecca Gray</u>		4 DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/1908</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harry Bell</u>		14. MOTHER'S MAIDEN NAME <u>Georgia Bennett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Shelton E. Gray, Vienna, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <u>3/7/67</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/9/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dor. Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cambridge Md</u>	
24. FUNERAL DIRECTOR <u>Edith S. Willoughby, East New Market, Md</u>		25. MAR 13 1967	
25a. REGISTRY ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03547

CERTIFICATE OF DEATH

03548

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN lb <u>27 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landing Neck, Trappe</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>John H. Harrison</u> First Middle Last 4. DATE OF DEATH <u>March 30</u> 19 <u>67</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-03-1881</u> 9. AGE (In years last birthday) <u>85</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm-r</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CIT ZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harrison William H.</u> 14. MOTHER'S MAIDEN NAME <u>Morgan, Matilda</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>216-54-9975</u> 17. INFORMANT <u>Spedden, Harrison</u> Address <u>401 Leonards Cambridge, Md. Gen.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Joint degenerative disease (advanced)</u> DUE TO (c) <u>10 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>7220</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 3</u> , 19 <u>67</u> , to <u>March 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 30</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Carlos F. Barros</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3-30-67</u>		22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROS</u> 22d. ADDRESS <u>Eastern Shore State Hosp. Dorchester Cambridge Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>4-1-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u> 23d. LOCATION (City or Town) (County) (State) <u>EASTON TALBOT MD</u>		24. FUNERAL DIRECTOR <u>Charles J. Jones</u> 25a. REC'D BY REGISTRAR <u>APR 3 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

FOR STATE
HEALTH DEPT

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03548

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03541

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
c. LENGTH OF STAY IN b. 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Beulah		d. STREET ADDRESS R.F.D. #2, Box 46	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOHN Last HUBBARD SR.		4. DATE OF DEATH Month March Day 30 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator		10b. KIND OF BUSINESS OR INDUSTRY Maryland Plastics	9. AGE (In years last birthday) 50
11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Fisher Hubbard		14. MOTHER'S MAIDEN NAME Mary Ida Hubbard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-10-9192	17. INFORMANT Address Mrs. Audrey Lee Hubbard, Hurlock, Md., RFD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 4/4/67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 2, 1967	23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery	23d. LOCATION (City or Town) Preston, Maryland (County) _____ (State) _____
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland ADDRESS		25a. RECD BY REGISTRAR APR 7 1967	25b. REGISTRAR'S SIGNATURE Charles George



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

03549

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03542

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b. COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
c LENGTH OF STAY in lb years		d STREET ADDRESS 1010 Washington Street	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Cambridge Maryland Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) LLOYD E. JAMES		4 DATE OF DEATH Month March Day 2 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 26, 1890
9 AGE (In years) 76		10 IF UNDER 1 YEAR Months Days Hours Mins	
11 BIRTHPLACE (State or foreign country) Hurlock, Maryland		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME William James		14 MOTHER'S MAIDEN NAME Hattie /?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO unk	
17 INFORMANT Mrs. Lloyd E. James, Cambridge, Maryland		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY 4d01 Coronary occlusion		INTERVA. BETWEEN ONSET AND DEATH Instant	
IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 3/3/67	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Cambridge, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Mar 5, 1967	
23c NAME OF CEMETERY OR CREMATORY Dorchester Memoria 1 Park		23d LOCATION (City or Town) (County) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a REC'D BY REGISTRAR DATE MAR 6 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



03550

CERTIFICATE OF DEATH

03543

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 10 wks.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital, Inc.		d. STREET ADDRESS R.F.D. #2 Cambridge, Md.	
3 NAME OF DECEASED (Type or print) First Middle Last Charles W. Jolley		4 DATE OF DEATH Month Day Year March 13 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 25, 1901
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	
11 BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Jolley, Sr.		14. MOTHER'S MAIDEN NAME Charolett Camper	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-38-0476	
17 INFORMANT Nettie Jolley		Address R.F.D. #2 Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Arteriosclerotic Cardiovascular Renal Disease DUE TO (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 14, 19 67 , to March 13, 19 67 , that (I) (we) last saw the deceased alive on March 13, 19 67 , and that death occurred at ----- M, from causes on and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 3-13-67	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 623 High Street Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/18/67	23c. NAME OF CEMETERY OR CREMATORY Bethel	23d. LOCATION (City or Town) (County) (State) Cambridge Dorchester Md.
24. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS Cambridge, Md.	25a. REC'D BY REGISTRAR DATE MAR 15 1967
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03551

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

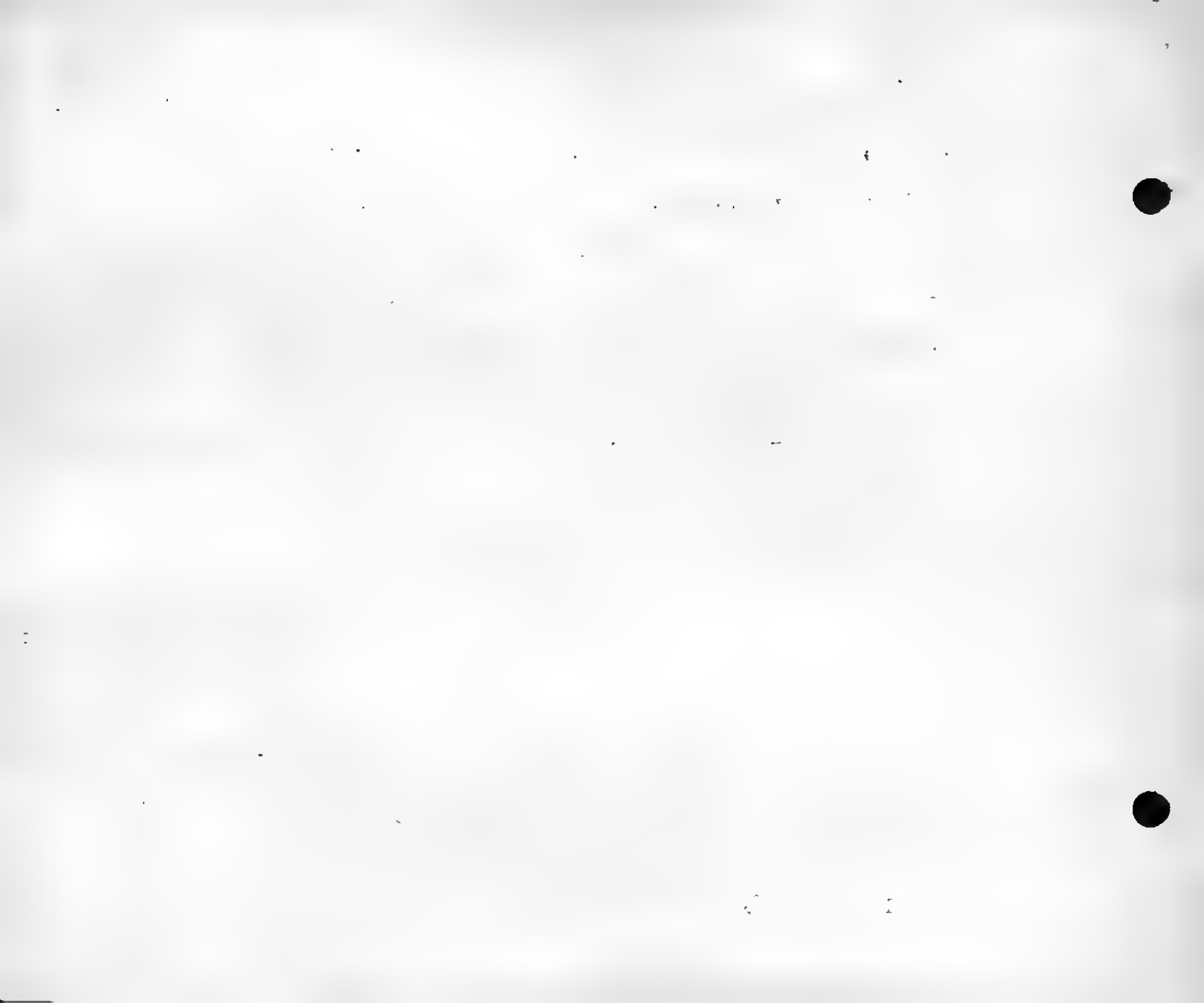
03544

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN b 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hurlock - Rural d. STREET ADDRESS RFD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Arch Jolley		4. DATE OF DEATH Month March Day 7 Year 1967	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 11, 1872	
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-52-8849	
17. INFORMANT Mrs. Rachel E. Johnson, Hurlock, Md., RFD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Neoplasm right Apex of lung		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 18, 1967 , to March 7, 1967 , that (I) (we) last saw the deceased alive on March 7, 1967 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. Edwin Fassett, M.D.		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 623 High St., Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 9, 1967	
23c. NAME OF CEMETERY OR CREMATORY Petersburg Cemetery		23d. LOCATION (City, town or county) (State) Near Hurlock, Maryland	
24. FUNERAL DIRECTOR J. J. Framptom and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR MAR 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03552 CERTIFICATE OF DEATH 03545									
1. PLACE OF DEATH a. COUNTY Dorchester					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN ID Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital					d. STREET ADDRESS 302 Nathan Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BRENDA Middle HORNER Last LARSON					4. DATE OF DEATH Month March Day 21 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1945		9. AGE (In years last birthday) 21 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Horner					14. MOTHER'S MAIDEN NAME Olive Larimore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. unk		17. INFORMANT Address Mr. Warren E. Larson, Cambridge, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 145X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Chronic Glomerular nephritis (c) Malignant hypertension and anemia									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19____, to 3-21-67 , 19____, that (I) (we) last saw the deceased alive on 3-20-67 , 19____, and that death occurred at 12:40 PM from the causes and on the date stated above.									
22a. SIGNATURE <i>Albert E. Bunker</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3-22-67	
22c. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER M. D.					22d. ADDRESS 200 1st Ave., Cambridge, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Mar 23, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland					25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		



FOR STATE
HEALTH DEPT.

03553

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03546

1 PLACE OF DEATH a COUNTY <u>Dorchester</u> MARYLAND <input checked="" type="checkbox"/>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Worcester</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c LENGTH OF STAY IN 1b <u>4 mon. 4 days</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d STREET ADDRESS <u>ELm Street, Route #1</u>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>Massey</u>		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/28/1888</u>
9 AGE (In years last birthday) <u>80</u> yrs.		# UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coast Guard</u>		10b KIND OF BUSINESS OR INDUSTRY <u>—</u>	11 BIRTHPLACE (State or foreign country) <u>MARYLAND USA</u>
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>George Wm. Massey</u>	
14 MOTHER'S MAIDEN NAME <u>Owllen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes Coast Guard 217-44-2042</u>	
16. SOCIAL SECURITY NO. <u>217-44-2042</u>		17 INFORMANT <u>East RN Shore State Hosp. (Medical Record)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)		INTERVAL BETWEEN DEATH <u>25 DAYS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> MD		22. DATE SIGNED <u>3/15/67</u>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b DATE THEREOF <u>3/18/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	
23d LOCATION (City or Town) (County) (State) <u>Berlin WORCESTER Md.</u>		25a REC'D BY REGISTRAR <u>MAR 17 1967</u>	
24 FUNERAL DIRECTOR <u>Anne A. Burbage</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

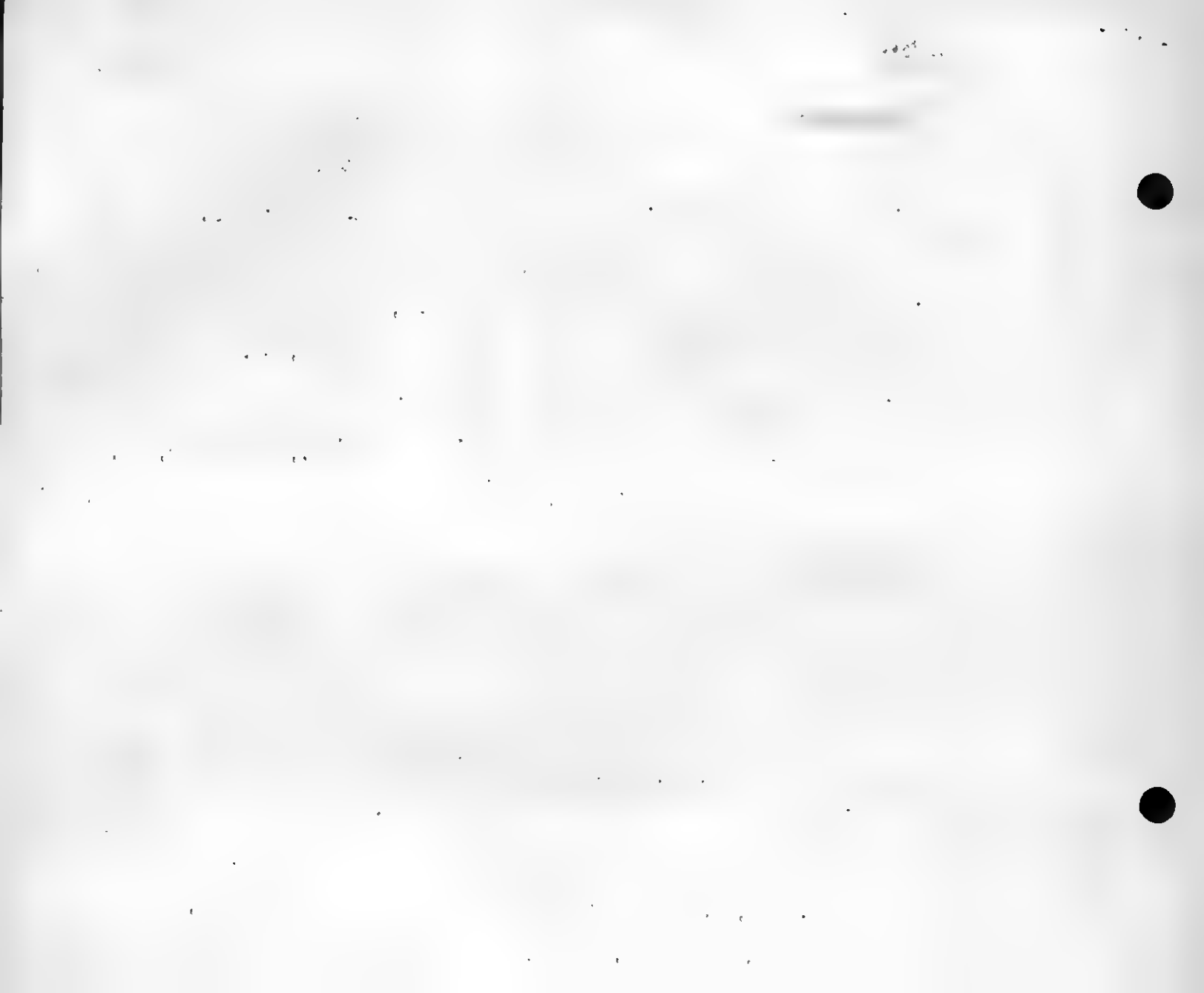
03554

03547

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>604 Glasgow Street</u>		d. STREET ADDRESS <u>604 Glasgow Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hilbert Edison Weekins</u>	4. DATE OF DEATH Month Day Year <u>Mar. 22, 1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1892</u>
9. AGE (In years last birthday) <u>74</u> yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cambridge</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>William W. Weekins</u>		14. MOTHER'S MAIDEN NAME <u>Manie E. Hackett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>...</u>	
17. INFORMANT <u>Mrs. Virginia J. Weekins, Cambridge, Md.</u>		Address <u>604 Glasgow St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/23/67</u>			
Address (Street, city, town, or county) <u>Cambridge, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 25, 1967</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ Churchyard</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>
23. FUNERAL DIRECTOR <u>Kenneth A. Thomas, Jr.</u> ADDRESS <u>Cambridge, Md.</u>			
24a. REC'D BY REGISTRAR <u>MAR 27 1967</u>			
24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH
10 Mins.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
03556					03549							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY Dorchester					a. STATE Maryland b. COUNTY Dorchester							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)							
Cambridge					Church Creek							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS							
Cambridge, Maryla nd Hospital					None							
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH							
First SARAH Middle KATHERINE Last MILLS					Month March Day 18, Year 19 67							
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)				
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan. 30, 1873		94 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife					Home		Madison, Maryland		USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME							
Columbus Hall					Susan Trego							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
No					214-54-9703		Mr. Carl R. Mills, Church Creek, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PYLORIC OBSTRUCTION										5 DAYS		
DUE TO (b) (UNDIETERMINED)												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 13 MAR 1967 to 18 MAR 1967 , that (I) (we) last saw the deceased alive on 17 MAR 1967 , and that death occurred at 10A M, from the causes and on the date stated above.												
22a. SIGNATURE W.F. GUNBY JR.										22b. DATE SIGNED 3/20/67		
22c. PHYSICIAN'S NAME (Type) W.F. GUNBY JR.										22d. ADDRESS CAMBRIDGE MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)				
Burial			Mar 21 1967		Greenlawn Cemetery			Cambridge, Maryland				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
LeCompte Funeral Service, Cambridge, Maryland							MAR 23 1967		Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03557

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03550

1 PLACE OF DEATH a COUNTY Dorchester MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Dorchester			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c LENGTH OF STAY IN 1b DOA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishops Head			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Cambridge Maryland Hospital				d STREET ADDRESS None		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First BRADY Middle W. Last MORRIS				4 DATE OF DEATH Month March Day 3 Year 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 3, 1905	9 AGE (In years and birthday) 62 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b KIND OF BUSINESS OR INDUSTRY Seafood		11 BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leander Morris				14 MOTHER'S MAIDEN NAME Anna Johnson			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) No		16 SOCIAL SECURITY NO unk		17 INFORMANT Address Mrs. Hazel M. Morris, Bishops Head, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: H201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 3/3/67 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.		22. DATE SIGNED	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Mar 5, 1967		23c NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d LOCATION (City or Town) (County) (State) Cambridge, Maryland	
24 FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland				25a REC'D BY REGISTRAR DATE MAR 6 1967		25b REGISTRAR'S SIGNATURE 	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03558

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03551

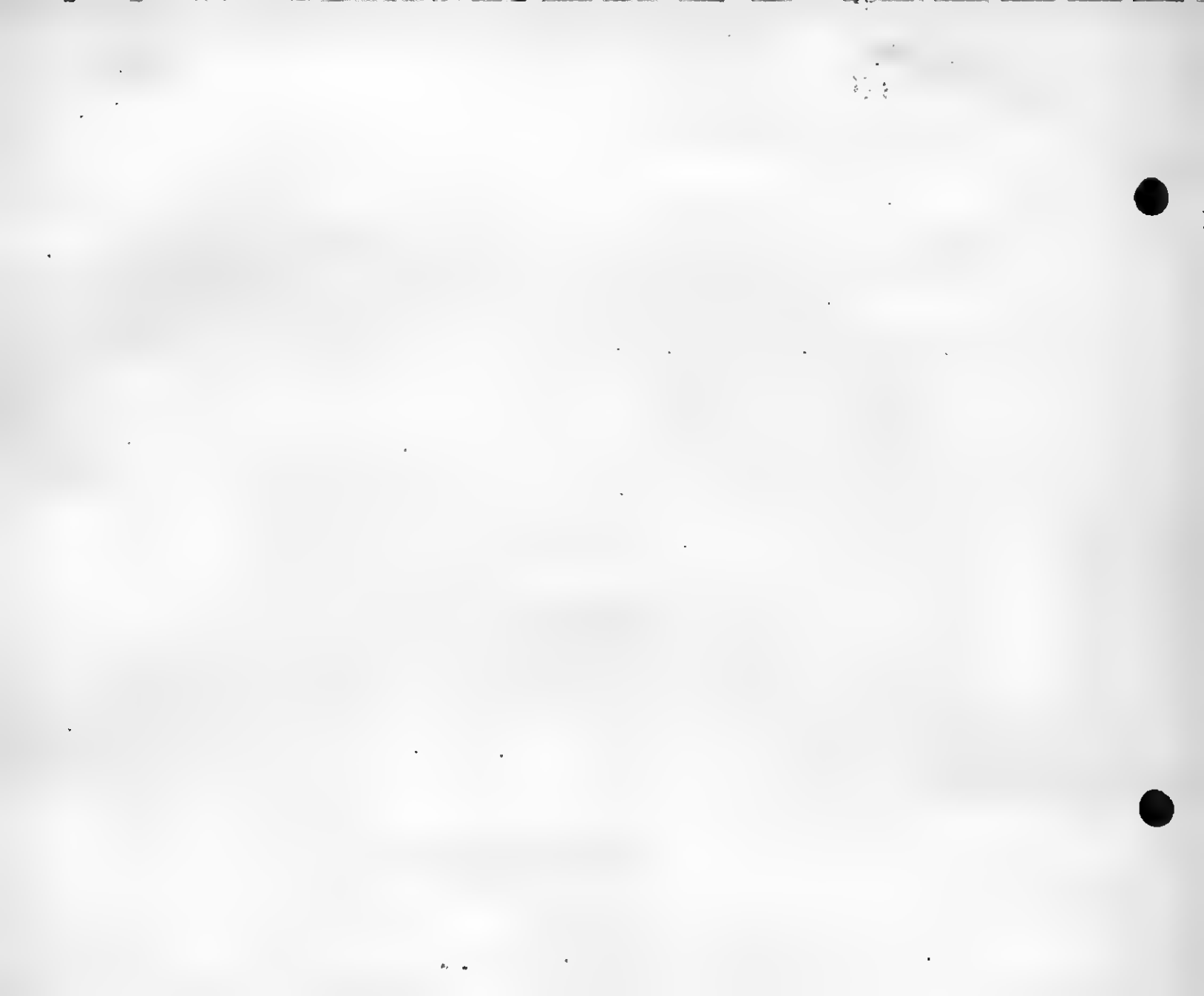
1 PLACE OF DEATH a COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c LENGTH OF STAY in lb 10 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS None	
3 NAME OF DECEASED (Type or print) First MARY Middle C. Last MURPHY		4 DATE OF DEATH Month March Day 25 Year 67	
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1894
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher-retired		10b KIND OF BUSINESS OR INDUSTRY School	
11 BIRTHPLACE (State or foreign country) East Freedom, Penna.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Michael C. Murphy		14. MOTHER'S MAIDEN NAME Ellen C. Murphy	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Miss Anne B. Murphy, Golden Hill, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism 9000 DUE TO (b) Fracture left femur DUE TO (c) 9 days.		INTERVA. BETWEEN ONSET AND DEATH 1 hr.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Fell down steps in home	
20c TIME OF INJURY Month, Day, Year 8:30 PM 3/15/67		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home	
20f (City or town) Golden Hill Dor.		(County) (State) Md.	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 3/27/67	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Mar 29, 1967	
23c NAME OF CEMETERY OR CREMATORY Star Of The Sea Cemetery		23d. LOCATION (City or Town) (County) (State) Golden Hill, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR MAR 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <div>035559</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>CERTIFICATE OF DEATH</div> <div>03552</div> </div> </div>															
1. PLACE OF DEATH a. CDUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u> c. LENGTH OF STAY IN 1b <u>30 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Belle Haven Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> d. STREET ADDRESS <u>Liberty Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>HERBERT</u> Last <u>O'DAY</u>			4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>19 67</u>		5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1878</u>		9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Painter</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Caroline County, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						
13. FATHER'S NAME <u>Charles O'Day</u>						14. MOTHER'S MAIDEN NAME <u>Rhoda Knox</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>158-14-9844</u>		17. INFORMANT <u>Mollie B. O'Day, Federalsburg, Maryland</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>Chronic bronchitis and emphysema</u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>10 days.</u> <u>10 years.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1967</u> , to <u>March 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 22, 1967</u> , and that death occurred at <u>10 A</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>Carlos F. Barroso</u>												22b. DATE SIGNED <u>March 22, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Carlos F. Barroso</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. 22d. ADDRESS <u>Hurlock, Maryland</u>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>March 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Federalsburg, Maryland</u>							
24. FUNERAL DIRECTOR <u>J. S. Frampton and Son, Federalsburg, Maryland</u>						25a. REC'D BY REGISTRAR <u>MAR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



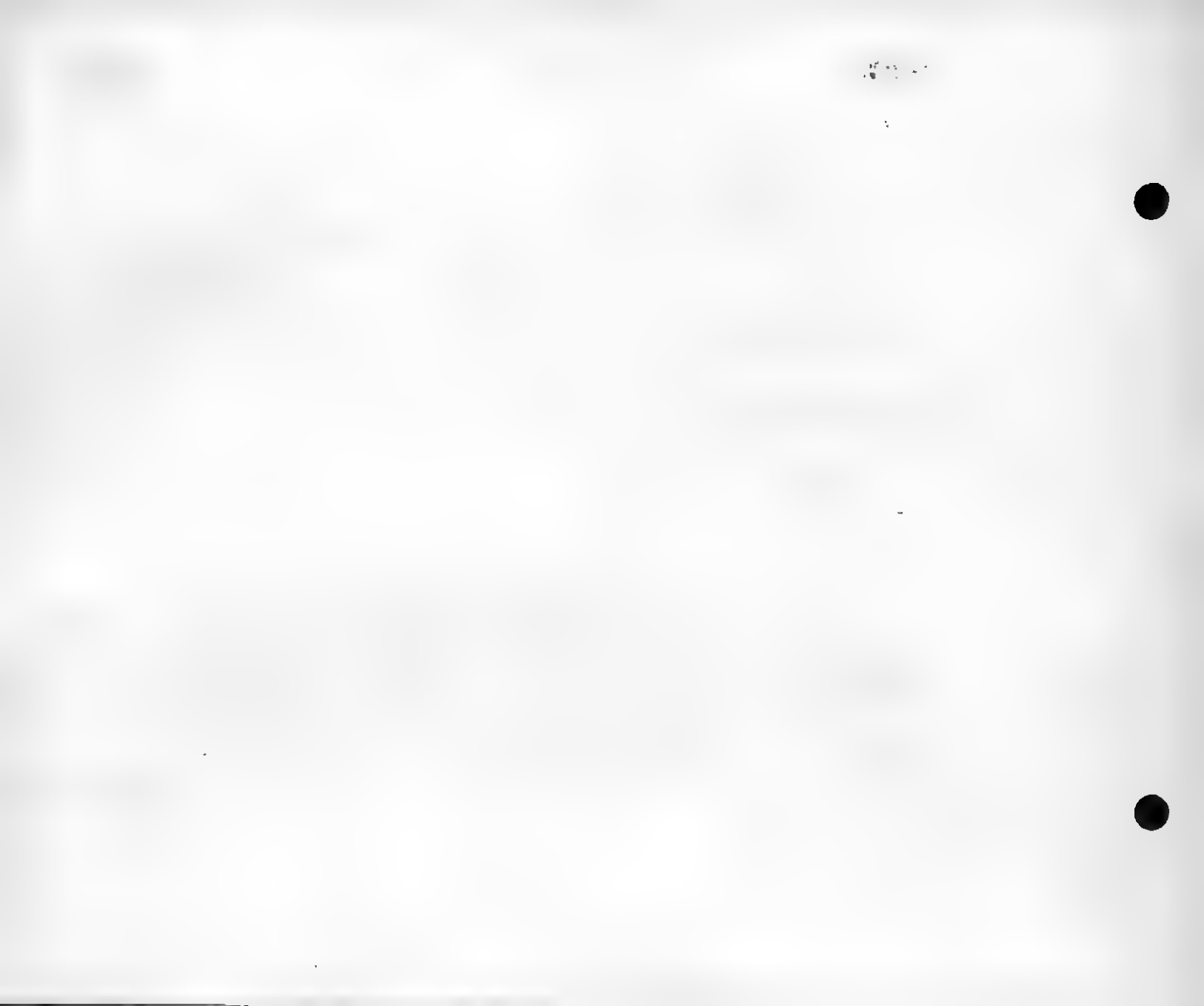
03560

CERTIFICATE OF DEATH

03553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>District</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>District</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>	
c. LENGTH OF STAY IN TB <u>4 years</u>		d. STREET ADDRESS <u>East New Market</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nancy Olivia Phillips</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-80</u>
9. AGE (In years lost birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State or foreign country) <u>District Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Phillips, Columbus Street</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Lord</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Eastern Shore State Hosp.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS, GENERALIZED</u> DUE TO (b) <u>CARCINOMA OF CERVIX</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVA. BETWEEN ONSET AND DEATH <u>ABOUT 1 YR</u> <u>ABOUT 1 YR</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) <u>ARTERIOSCLEROSIS, CHRONIC BRAIN SYNDROME</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u> </u> (this hospital) attended the deceased from <u>NOV. 19, 1966</u> , to <u>MAR. 19, 1967</u> , that (1) <u> </u> last saw the deceased alive on <u>MAR. 19, 1967</u> , and that death occurred at <u>12:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward Lewis, Jr. M.D.</u>		22b. DATE SIGNED <u>3-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR., M.D.</u>		22d. ADDRESS <u>Eastern Shore State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	23d. LOCATION (City or Town) (County) (State) <u>East New Market, Md.</u>
24. FUNERAL DIRECTOR <u>Edith S. Hollingsworth</u>		25. REC'D BY REGISTRAR <u>MAR 21 1967</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03561 CERTIFICATE OF DEATH 03554

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 101 Glenburn Avenue		e. STREET ADDRESS 101 Glenburn Avenue	
3. NAME OF DECEASED (Type or print) First REGINALD Middle JAMES Last PHILLIPS		4. DATE OF DEATH Month March Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1898
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter-Retired		11b. KIND OF BUSINESS OR INDUSTRY General Building	
11c. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levin H. Phillips		14. MOTHER'S MAIDEN NAME Emma Brannock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Mrs. Reginald J. Phillips, Cambridge, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) Adenocarcinoma Lung OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 1967, to March 22 , 1967, that (I) (we) last saw the deceased alive on March 22 , 1967, and that death occurred at 4:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Wilbur N. Baumann, MD		22b. DATE SIGNED 3-23-67	
22c. PHYSICIAN'S NAME (Type) Wilbur N. Baumann, MD		22d. ADDRESS 10 Aurora St., Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 25 1967	
23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR MAR 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

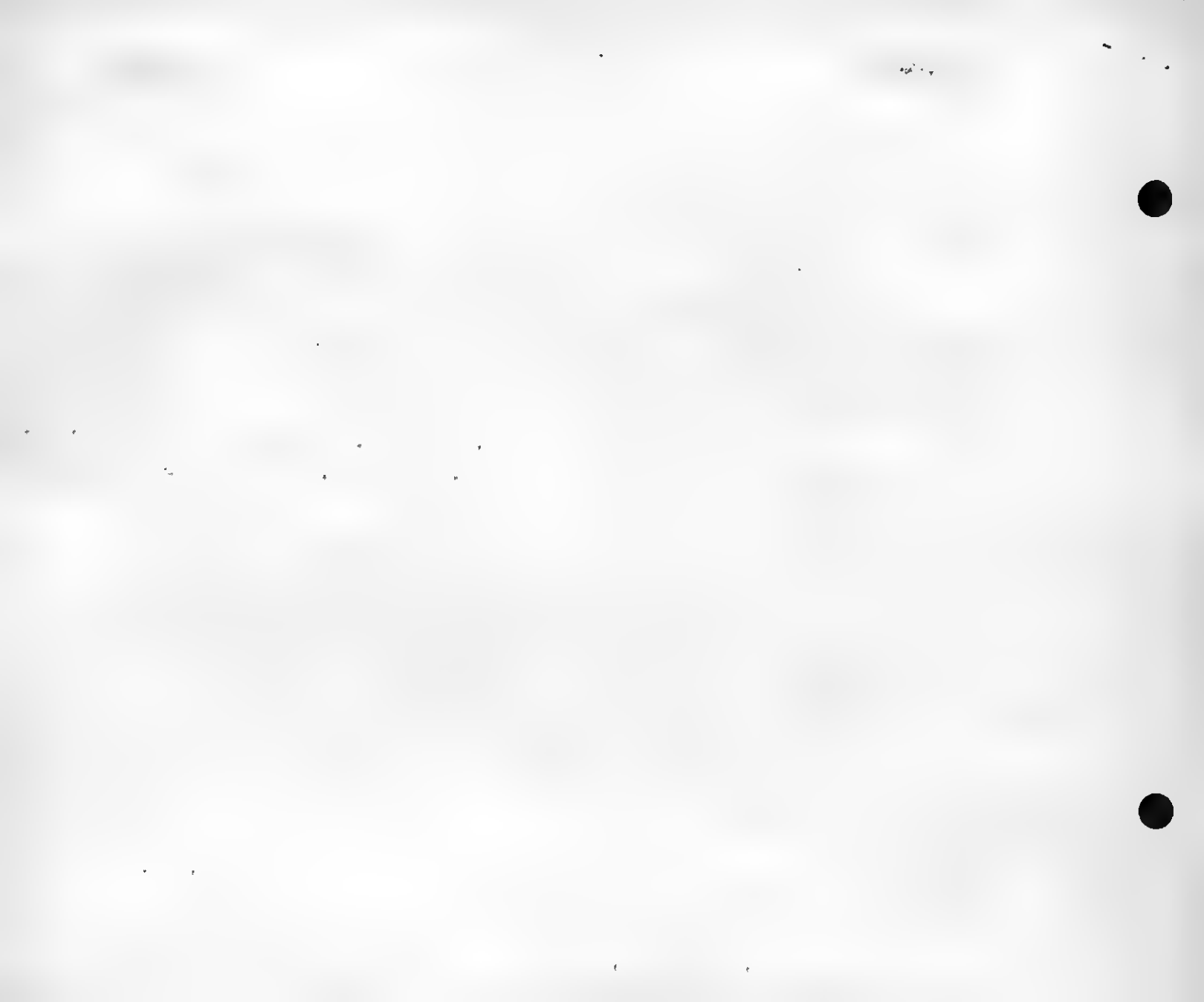
<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>03562</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>Item #2d Film #3386 3/9/67 pc</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>03555</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b 15 years		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cambridge				
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1005 Race Street					4. STREET ADDRESS 1005 1405 Race Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HATTIE Middle SLACUM Last PRITCHETT					4. DATE OF DEATH Month March Day 2 Year 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1877		9. AGE (n years last birthday) 89 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Lemuel Slacum					14. MOTHER'S MAIDEN NAME Alice Pritchett				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO No		17. INFORMANT Address Mrs. George Powley, Wingate, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr. M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park			23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland					25a. REC'D BY REGISTRAR DATE MAR 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03563				CERTIFICATE OF DEATH				03556			
1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c LENGTH OF STAY IN 1b <u>3 mos</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md</u>					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>						d STREET ADDRESS <u>1002 Bell LA Ave</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Julia Chark Rawson</u>						4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1967</u>					
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>01-01-89</u>		9 AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months <u>2</u> Days <u>11</u> Hours <u></u> Min <u></u>	
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Retired) Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>						14 MOTHER'S MAIDEN NAME <u>Unknown</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-30-09468</u>		17 INFORMANT <u>Mr. Joseph B. Rawson</u> Address <u>Salisbury, Md.</u>				18 <u>& Mr. William H. Rawson (Step-son)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA + emphysema?</u>											
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>											
DUE TO (c) <u></u>											
PART 1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <u>OBESITY, DIABETES MELLITUS, ARTERIOSCLEROSIS</u>											
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) <u>N/A</u>					
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20a INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-14</u> , 19 <u>66</u> to <u>3-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-12-67</u> at <u>8:45 AM</u> , and that death occurred at <u>8:45 AM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Felipe M. Dominguez</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-12-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>FELIPE M. DOMINGUEZ</u>						22d ADDRESS <u>E.S.S.D Cambridge, Md.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b DATE THEREOF <u>March 15, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>	
24 FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>						25a. REC'D BY REG STRAR <u>MAR 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>William Dudge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03564

03557

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 2 hrs. 32 Min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital Inc.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 744 Cornish Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sampson Middle Sampson Last Sampson		4. DATE OF DEATH Month March Day 24 Year 19 67	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1967
9. AGE (in years last birthday) 2 yrs. 32 Months 2 Days 32		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Dorchester	
13. FATHER'S NAME Joe Louis Sampson		14. MOTHER'S MAIDEN NAME Doretha Leona Travers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT Doretha Sampson-744 Cornish Dr. Camb. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity---Immaturity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-24 , 19 67 , to 3-24 , 19 67 , that (I) (we) last saw the deceased alive on 3-24 , 19 67 , and that death occurred at 9:50 AM from the causes and on the date stated above.			
22a. SIGNATURE Eldridge H. Wolff		22b. DATE SIGNED 3-24-67	
22c. PHYSICIAN'S NAME (Type) Dr Eldridge H. Wolff		22d. ADDRESS 6 Aurora St Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Disposed of		23b. DATE THEREOF 3-25-67	
23c. NAME OF CEMETERY OR CREMATORY Cambridge Maryland Hospital		23d. LOCATION (City, town or county) (State) Cambridge Maryland	
24. FUNERAL DIRECTOR Irma Skinner		25a. REC'D BY REGISTRAR Charles Jones	
25b. REGISTRAR'S SIGNATURE		25c. DATE MAR 29 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03565		CERTIFICATE OF DEATH						03558			
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryla nd Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East New Market d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROBIN LYNN SCHUYLER						4. DATE OF DEATH March 4, 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1965		9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Easton, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Nathan L. Schuyler						14. MOTHER'S MAIDEN NAME Juanita Mae Greenhawk					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Nathan L. Schuyler, East New Market, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia - Iron deficiency - dehydration										INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 3-3, 1967 to 3-4, 1967 that (I) (we) last saw the deceased alive on 3-4, 1967 and that death occurred at 5 1/2 M. from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						22b. DATE SIGNED 3-6-67		22c. PHYSICIAN'S NAME (Type) [Signature]			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park			23d. LOCATION (City, town or county) (State) Cambridge, Maryland				
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland						25a. REC'D BY REGISTRAR MAR 9 1967		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03566

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03559

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First EDDIE Middle A. Last SEWARD				4. DATE OF DEATH Month March Day 18 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 28, 1885	
				9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hudson, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John W. Seward				14. MOTHER'S MAIDEN NAME Carrie Palmer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-54-7346		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PERIPHERAL CIRCULATORY FAILURE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PULMONARY DECOMPENSATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY DECOMPENSATION							INTERVAL BETWEEN ONSET AND DEATH 12 HRS UNDER
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/16 , 19 67 , to 3/18 , 19 67 , that (I) (we) last saw the deceased alive on 3/18 , 19 67 , and that death occurred at 6 PM , from the causes and on the date stated above.							
22a. SIGNATURE Alfred R. Maryanov				22b. DATE SIGNED 3/20/67			
22c. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV				22d. ADDRESS 610 RACE ST, CAMBRIDGE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 21 1967		23c. NAME OF CEMETERY OR CREMATORY Spedden-Seward Cemetery		23d. LOCATION (City, town or county) (State) James, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR MAR 23 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

03567

CERTIFICATE OF DEATH

03560

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND x		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Taibot</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels Maryland</u>	
c. LENGTH OF STAY IN IB <u>16 mos 26 days</u>		d. STREET ADDRESS <u>20-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>A</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02-17-71</u>
9. AGE (In years lost birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR Months <u>26</u> Days <u>26</u> Hours <u>26</u> Min. <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFARER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sturwood, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>219-20-9228</u>	
17. INFORMANT <u>Eastern Shore State Hosp. (Medical Record)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>? myocardial infarction</u> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>N.A.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>10-19-</u> , 19 <u>65</u> , to <u>3-15-</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>3-15-</u> 19 <u>67</u> , and that death occurred at <u>6:18</u> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>John Blair Webster</u>		22b. DATE SIGNED <u>3-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN BLAIR WEBSTER</u>		22d. ADDRESS <u>CAMBRIDGE, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 17, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>St. Michaels Maryland</u>	
24. FUNERAL DIRECTOR <u>Harmon Leonard</u>		25a. REC'D BY REGISTRAR <u>St. Michael</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		MAR 20 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03283

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03568				Items 13 & 14 Film 0387-1/17/67-nb				03561			
1. PLACE OF DEATH a. COUNTY Dorchester				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md.				b. COUNTY Dorchester			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b life				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS 210 Belvedere Ave/				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) S. Earl Webster				4. DATE OF DEATH 3/6/67				Month 19			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/1904		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) druggist				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Crapo, Dorchester, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie Worton/ Samuel Dewberry Webster				14. MOTHER'S MAIDEN NAME Dewberry Willie I. Worton							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. unk.				17. INFORMANT Mrs. Evelyn Robinson Webster, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial Infarction 4801 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Arterio-sclerosis generalized										INTERVAL BETWEEN ONSET AND DEATH 12 Min. 6 Mo. 1 Yr. +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Lymphatic Leukemia, asymptomatic										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from 1-4- , 19 67 , to 3-6- , 19 67 , that (I) (the) last saw the deceased alive on 3-6- , 19 67 , and that death occurred at 8:20 A. from the causes and on the date stated above.											
22a. SIGNATURE Eldridge A. Wolff				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 3-7-67			
22c. PHYSICIAN'S NAME (Type) Eldridge M. Wolff, M. D.				22d. ADDRESS 6 Aurora Street, Cambridge, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/67		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park Cambridge, Md. Dorchester				23d. LOCATION (City, town or county) (State) Dorchester			
24. FUNERAL DIRECTOR LeCompte Funeral Service Cambridge, Md.				25a. REC'D BY REGISTRAR MAR 13 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

03561

03561

Chronic infectious leukemia, myelomatous

Atypical infectious myelomatous

Chronic infectious myelomatous

Chronic infectious myelomatous

Chronic infectious myelomatous

Chronic infectious myelomatous